Annual Review 1985

Office of the Chief Medical Examiner

Alberta
ATTORNEY GENERAL

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Caseload Review 1975 - 85

	Calgary	South Rural	Edmonton	North Rural	Provincial Total
1975	664	656	689	741	2,750
1976	669	572	602	764	2,607
1977	678	800	658	827	2,963
1978	783	796	902	911	3,392
1979	920	876	1,084	975	3,855
1980	1,011	957	1,142	983	4,093
1981	944	934	1,223	917	4,018
1982	973	838	1,325	884	4,020
1983	965	826	1,295	849	3,935
1984	748	875	1,286	908	3,817
1985	633	874	1,244	849	3,600

Refereed Case Review*

	1981	1982	1983	1984	1985
Calgary	323	295	304	463	601
South Rural	70	45	104	158	91
Edmonton	124	98	225	201	303
North Rural	41	45	58	61	81
TOTAL	558	483	691	883	1,076

* "Refereed" cases are deaths reported to the Medical Examiner according to Section 15 of the Vital Statistics Act, deferred to the attending physician on the basis that the death was natural, that he is able to certify the medical cause of death with reasonable accuracy and that he has received the consent of the Medical Examiner.

Types of Death Investigated and Certified

Homicides

	Male	Female	Total
Calgary	9	6	15
Edmonton	15	11	26
North Rural	5	4	9
South Rural	9	5	14
TOTAL	38	26	64

Method

Fight/brawl	7
Hanging/strangulation	2
Firearms	17
Stabbing/incised wound	26
Child battery	1
Drowning	1
Poison	1
Other/unspecified	9
TOTAL	64

Suicides

Age Group	Male	Female	Total	Rate/100,000 Pop.
5 - 9	1	0	1	0.6
10 - 14	2	1	3	1.8
15 - 19	25	7	32	17.1
20 - 24	47	6	53	22.6
25 - 29	44	14	58	22.4
30 - 34	33	9	42	18.9
35 - 39	30	10	40	21.9
40 - 44	30	12	42	31.1
45 - 49	17	11	28	25.4
50 - 54	19	5	24	23.5
55 - 59	18	3	21	22.6
60 - 64	12	2	14	17.5
65 - 69	7	3	10	16.2
Over 70	21	6	27	22.0
TOTAL	306	89	395	16.9

Month of Death

	Calgary	Edmonton	North Rural	South Rural	Total
January	6	15	8	16	45
February	13	11	6	8	38
March	11	4	7	6	28
April	12	7	14	7	40
May	6	13	7	4	30
June	7	15	10	10	42
July	6	4	9	11	30
August	7	8	14	5	34
September	10	4	5	6	25
October	8	10	10	4	32
November	8	6	5	6	25
December	11	5	5	4	25
Unknown	—	—	—	1	1
TOTAL	105	102	100	88	395

Suicides 1975 - 1985

	1975	1976	1977	1978	1979	1980	1981	1982	1983	1984	1985
Calgary	78	84	88	90	83	103	94	109	106	82	105
South Rural	69	60	76	79	56	91	70	63	70	83	88
Edmonton	68	97	89	84	104	99	97	112	120	135	102
North Rural	72	78	97	81	82	107	103	97	124	123	100

Suicide Rates Per 100,000 Population

Year	Estimated Population (000's)	Total Suicides	Rate/ 100,000	Year	Estimated Population (000's)	Total Suicides	Rate/ 100,000
1960	1,291.1	115	8.9	1973	1,689.5	222	13.1
1961	1,332.0	120	9.0	1974	1,722.4	281	16.3
1962	1,369.0	120	8.8	1975	1,811.8	287	15.8
1963	1,402.0	118	8.4	1976	1,885.2	319	16.9
1964	1,430.0	162	11.3	1977	1,965.8	350	17.9
1965	1,450.0	162	11.2	1978	2,028.8	334	16.5
1966	1,463.2	145	9.9	1979	2,109.6	325	15.4
1967	1,490.0	135	9.1	1980	2,205.1	400	18.1
1968	1,524.0	160	10.5	1981	2,293.5	364	15.9
1969	1,559.0	195	12.5	1982	2,347.7	381	16.2
1970	1,595.0	204	12.8	1983	2,361.0	420	17.8
1971	1,627.9	191	11.7	1984	2,300.0	423	18.1
1972	1,675.3	212	12.6	1985	2,348.8	395	16.9

Method

	Male	Female	Total	Percentage
Drug overdose/poison	31	34	65	16
Carbon monoxide	61	28	89	23
Hanging/strangulation	67	13	80	20
Submersion	2	2	4	1
Firearms	121	8	129	33
Incised wounds	8	0	8	2
Jumping	10	3	13	3
Other	6	1	7	2
TOTAL	306	89	395	100

National Suicide Rates* Per 100,000 Population 1975 - 1985

	1975	1976	1977	1978	1979	1980	1981	1982	1983	1984	1985
National Rate	12.4	12.8	14.3	14.8	14.1	14.0	14.0	13.9	15.1	13.7	12.9
Newfoundland	3.5	3.8	3.7	2.6	4.4	3.4	4.2	6.0	6.2	6.7	4.0
Prince Edward Island	11.9	19.5	10.0	13.1	13.1	11.4	7.4	8.9	12.9	12.0	3.9
Nova Scotia	10.4	10.4	11.3	12.5	12.6	11.5	10.9	12.2	12.1	9.9	12.0
New Brunswick	8.0	10.9	10.5	12.9	12.1	11.6	11.1	12.9	14.2	12.6	12.0
Quebec	9.3	10.5	12.4	14.2	15.4	14.8	16.4	16.5	18.5	15.7	17.1
Ontario	13.5	13.0	14.5	14.3	13.0	13.1	12.5	12.7	12.9	12.3	11.4
Manitoba	13.1	14.1	17.5	15.4	14.7	11.8	14.0	13.4	15.8	12.7	11.9
Saskatchewan	14.9	14.0	15.6	17.3	14.9	15.9	17.7	17.5	14.9	13.5	13.0
Alberta	15.8	16.9	17.9	16.5	15.4	18.1	15.9	16.2	16.7	17.2	16.9
British Columbia	16.9	16.4	17.6	18.3	16.2	14.8	14.5	15.0	14.8	13.4	10.4
Yukon**	1.9	1.8	2.4	3.2	2.7	5.0	2.2	2.9	3.6	2.3	3.5
Northwest Territories**	1.7	1.6	2.8	5.5	1.8	2.0	2.2	1.7	4.3	3.4	2.5

*Source: Statistics Canada

**Rates based on 10,000 population.

Motor Vehicle Fatalities

Motor Vehicle Accidents	
Driver	285
Passenger	158
Unknown occupant	1
Subtotal	444
Pedestrians Struck by Motor Vehicle	56
Motorcycle Accidents	32
Train Collisions	
Driver of motor vehicle	5
Passenger in motor vehicle	1
Pedestrian	6
Subtotal	12
Bicycle Accidents	6
Motor Vehicle Collapsed on Victim	2
Trapped in Car; Drowned	1
Stillborn Following Accident	1
TOTAL MOTOR VEHICLE FATALITIES	554

Non-Traffic Accidents

Industrial

Crushed by equipment	8
Crushed by other objects	7
Crushed by vehicles	7
Electrocution	1
Explosion	5
Fall	4
Hit by train	1
Hit by tree	3
Overcome by gases	6
TOTAL	42

Farm

Equipment roll over	10
Crushed by machinery	4
Run over by machinery	3
Cleaning well; overcome by methane gas	2
Cleaning pigsty; overcome by methane gas	2
Hit by bales of hay	2
Trench cave-in	1
Head caught in swather	1
Crushed between truck chassis and grain box	1
Clothing entangled in power take-off	1
Welding fuel tank exploded	1
Hit animal while herding cattle with motorcycle	1
Hypothermia; pinned by bar while fixing baler	1
Stuck in baler	1
Hit irrigation canal while riding motorcycle	1
TOTAL	32

Other

Adverse drug reaction	1
Aircrash	19
All-terrain vehicle	3
Asphyxia/aspiration	20
Carbon monoxide	13
Crushed by bull	1
Crushed by object	4
Dirtbike	3
Drowning	52
Drag crew member crushed	1
Drug overdose	5
Electrocution	3
Fall	83
Fall from bicycle	1
Fall from horse	3
Fall while hiking	1
Firearm	6
Fire	37
Hypothermia	11
Kicked by horse	1
Late effects of trauma	8
Lightning	1
Parachute	3
Snowmobile	5
Skiing	1
Therapeutic misadventure	3
Ultralight	1
TOTAL	290

TOTAL MOTOR VEHICLE/ACCIDENTAL DEATHS 918

Unclassified Deaths*

Causes of Death

Chronic and/or acute alcoholism and sequelae	104
Drug overdose	19
Alcohol and drug overdose	14
Hypothermia due to intoxication	6
Methyl alcohol	5
Fall related to intoxication	2
Aspiration of food due to intoxication	1
Drowning due to intoxication	1
TOTAL	152

*Evidence of alcoholism or drug misuse is a direct part of the primary medical cause of death.

Undetermined Deaths*

Causes of Death

Unable to determine exact cause of death	27
Drug overdose	18
Other or unspecified	10
Carbon monoxide	5
Drowning	5
Jump before moving object	3
Burns, fire	3
Unspecified substances	3
Firearms	3
Fall	2
Asphyxia	2
Motor vehicle accident	1
Blow to head	1
Hypothermia	1
Bicycle	1
Late effects	1
TOTAL	86

*Undetermined whether accidental, self-inflicted, or homicide.

Sudden Infant Death Syndrome

Age Group	Calgary	South Rural	Edmonton	North Rural	Total
Less than 1 month	0	3	1	0	4
1 - 3 months	8	8	22	19	57
4 - 6 months	2	4	2	6	14
7 months and older	1	1	2	2	6
TOTAL	11	16	27	27	81

Sudden Infant Death Syndrome is the leading cause of death among infants from one week to one year of age. In Alberta, S.I.D.S. accounted for 81 infant deaths in 1985. The overall incidence of S.I.D.S. has been reported as 1.8 cases per 1,000 live births. Although it can occur at any time during the first year of life, the peak incidence in Alberta is during the first three months.

S.I.D.S. Statistics for Selected Cities

	1980	1981	1982	1983	1984	1985
Calgary	14	22	24	15	12	11
Edmonton	17	25	26	26	22	27
Lethbridge	3	2	4	0	1	1
Fort McMurray	0	0	1	0	3	1
Red Deer	4	1	1	1	0	1
St. Albert	0	0	1	0	1	0
Medicine Hat	2	2	1	2	2	1
Leduc	0	0	1	0	1	0
Grande Prairie	0	0	1	0	2	0
Camrose	0	0	1	0	0	0

Public Inquiries

Public Inquiries Summary

(January 1, 1985 - December 31, 1985)

Manner of Death	Judicial Recommendations for the Prevention of Similar Deaths: Given	Not Given	
Natural	4	7	
Homicidal	1	1	
Suicidal	6	3	
Accidental	12	9	
Unclassified	0	0	
Undetermined	0	1	
TOTAL	23	21	= 44

Types of Public Inquiries

Hospital/Institutional Related

Natural	5
Suicide	4
Accidental	
Drug and alcohol abuse	2
Drug misadventure	1
Surgical misadventure	1
Choked	1
TOTAL	14

Motor Vehicle Related

Collisions	7
Other	1
TOTAL	8

Occupational Related

Hit by pipe	1
Hit by train	1
Hit by grinding disk	1
TOTAL	3

Police/Incarceration Related

Suicide	3
Natural	1
Homicide	1
Drug and alcohol overdose	1
Fall	1
TOTAL	7

Other

Suicide	3
Natural	2
Undetermined	2
Accidental	
Asphyxia	1
Crib collapsed	1
Choked on wiener	1
Struck by boat	1
Drowned in bathtub	1
TOTAL	12

TOTAL PUBLIC INQUIRIES **44**

1985 Public Inquiry Summaries

Case History 1

Natural. Passenger on a bus appeared to the driver to be extremely intoxicated when removed; appeared intoxicated to police officers who took deceased to Medicine Hat Hospital.
Emergency physician did not perform diagnostic tests or consider diabetes as a possible diagnosis.

Recommendations:

Patients who are unable to give a full medical history should be kept under medical, not police, observation. Further tests — beyond confirming the obvious — may be indicated.

Replies:

ALBERTA HOSPITALS AND MEDICAL CARE

The intent of this recommendation has been brought to the attention of all hospital administrators with a request that they ensure that appropriate policies and procedures are in place to reduce the potential for similar instances to occur.

MEDICINE HAT & DISTRICT HOSPITAL

We have instructed Medical Staff to follow these recommendations, and we are not aware of any case where the recommendations have not been followed.

Case History 2

Natural. Decedent on leave from Alberta Hospital, Ponoka. Patient consumed alcohol while taking medication.

Recommendations:

All containers of medicine and prescription drugs carry a written warning about the use of alcohol while taking medication.

Replies:

ALBERTA HOSPITALS AND MEDICAL CARE

The recommendations were referred directly to the hospital.

ALBERTA HOSPITAL, PONOKA

A procedure has been instituted for labelling prescription containers dispensed on discharge, leaves of absence, trial visits, and self-medication from the pharmacy.

Case History 3

Suicide. Inmate of Drumheller Institution was placed in segregation under periodic observation, where he committed suicide.

Recommendations:

1. Recommendations of the Administrative Inquiry to be implemented immediately.
2. Procedures in standing orders be communicated to all guards and be properly carried out as stated.

Replies:

CORRECTIONAL SERVICE CANADA

1. Recommendations of the judge are being actioned.
2. Strip cell in place, closed circuit cameras/monitors ordered.
3. Suicidal clothing and bedding is on site and in use when necessary.
4. Shift briefings have been improved to include such concerns.
5. Security has completed the divisional review of the Commissioner's Directives and Standing Orders.
6. Inmates on suicide watch in Building 5 are placed in a cell close to the Officer's office and appropriate equipment is being used.

ALBERTA SOLICITOR GENERAL

1. Detailed policies and procedures for dealing with suicidal inmates have recently been updated.
2. Each correctional centre is required to review these policies as they are issued and subsequently is required to issue Standing Operating Procedures to carry out provincial policy.
3. Each centre required to house suicidal inmates has an area designated and well supervised. Policy requires either constant supervision or 15-minute checks depending on the situation.
4. In new centres there will be one cell which will have closed camera television for continuous monitoring. When the closed camera television system in existing centres is updated this item will be addressed.
5. Policies concerning clothing, bedding and furnishings in the cell for suicidal inmates are in line with the recommendation.

Case History 4

Accidental. Decedent was struck from behind by a train while pushing his patrol rider out of the way.

Recommendations:

All railway patrol riders or cars be equipped with fully functional radio communicator which is audible at all times and on the same frequency as all trains using tracks and with all main yards so that all patrol cars are aware of the position of all trains at all times and so that an oncoming or trailing train can warn patrol cars in sufficient time to take steps to prevent a collision.

Replies:

CANADIAN PACIFIC

Recommendations with respect to radio communications have been addressed and this situation has been corrected.

TRANSPORT CANADA

1. Compliance with existing safety procedures would have prevented the accident.
2. As the recommendations suggest, improved equipment rather than changes in the fundamental safety rules which govern the work practices of railway, would be beneficial. Therefore, no action beyond ensuring adequate review by the railway will be undertaken. All concerned railway employees have been reminded not to place considerations for property before their own personal safety.

Case History 5

Natural. Decedent was a patient of Alberta Hospital, Ponoka. Empty medication bottles were found the day prior to his death.

Recommendations:

Although the drugs were not felt to be the cause of death, medication obviously was secreted or held by the patient without the knowledge of the hospital. It is suggested that a closer examination of the effects of the patient would prevent this.

Replies:

ALBERTA HOSPITALS AND MEDICAL CARE

Referred this matter directly to the hospital for their attention and follow up.

ALBERTA HOSPITAL, PONOKA

1. Check the prescribed medications in the patient's possession prior to and after return from day pass, leave of absence and also upon return from unauthorized leave of absence.
2. Institute immediate search of patient's room, cupboards and belongings where there is abrupt change in medical, psychiatric status such as acute anxiety, agitation, pronounced drowsiness, dizziness, confusion or disorientation.

Case History 6

Accidental. Head-on collision between two vehicles on Alberta Highway No. 3. Driver of one vehicle had a long history of mental and physical problems and was impaired at the time of the accident.

Recommendations:

1. Increased visible police enforcement.
2. Raise the minimum drinking age.
3. The blood alcohol content that should be permitted for drivers younger than 21 ought to be 50 mg% instead of 80 mg%.
4. Setting curfews for new drivers.
5. Lengthier suspension of driving privileges for offenders under 21.
6. Upon a second conviction for impaired driving or related charge the offender be thus "publicly branded".
7. Section 14 (2) Motor Vehicle Act of Alberta should be made mandatory.
8. Law officers of the Provincial Crown should monitor developments in respect to the above-mentioned amendments to the Government of Canada legislation.
9. Place the heading 'air bags' high on the list of items under heading "Recommended for Future Study".

Replies:

ALBERTA MEDICAL ASSOCIATION

1. Many of the recommendations of the judge have been made by the Alberta Medical Association throughout the years; particular emphasis should be placed on the Alberta Medical Association stand on seat belts, which goes beyond that of the judge.
2. While the recommendation for separate treatment of the under-21 driver and for the problem drinker have merit, they are very unlikely to be accepted politically. This would probably be very difficult to enforce.
3. Routine, mandatory reporting of persons medically unfit to drive would cause concern amongst some members of the profession.

ALBERTA TRANSPORTATION

Those recommendations that apply to Alberta Transportation's area of responsibility will be closely examined to determine what action is feasible and to take action where appropriate.

ALBERTA COLLEGE OF PHYSICIANS AND SURGEONS

We do circulate to the profession from time to time relevant sections of the Alberta Motor Vehicle Administration Act. We do advise physicians who telephone of the importance of such reports in the prevention of severe injury or death.

ATTORNEY GENERAL OF CANADA

1. On December 4, 1985 new impaired driving laws in the Criminal Code came into force.
2. Department of Justice has launched a public education campaign and plans are underway for the implementation of a long-term program by the government.
3. The Department intends to examine with the provinces the raising of the legal age for purchase and consumption of alcohol and for the possibility of a separate offence with a lower blood-alcohol concentration level for young persons.
4. The Department of Justice and the Law Reform Commission of Canada are currently reviewing the laws concerning appeals and sentencing.

ALBERTA SOLICITOR GENERAL

1. The Minister has authorized the Law Enforcement Division to establish, in concert with the police, a new Police Impaired Driving Committee. The purpose of the committee is to promote new and innovative ways for the police and this Department to reduce the incidence of impaired driving. Publicity campaigns and stepped-up enforcement are addressed by the committee.
2. With regard to raising the drinking age, setting curfews for new drivers and lengthier suspensions of driving privileges, the Department will research this matter with all other North American licensing jurisdictions that have these programs in effect, to see if there is any measure of effectiveness to such programs before recommending any changes.
3. With respect to recommendation 6, this is an area that the Department is currently reviewing in terms of gathering information from other jurisdictions that may have similar programs in place, before making any further decision.
4. The matter of recommendation 7 is currently under review. To date correspondence has been exchanged between the Department, the Alberta Medical Association and the Alberta Association of Optometrists in terms of gathering input.
5. The Law Enforcement Division has received information about changes in the Aeronautics Act which require physicians and optometrists to report on the condition of holders of Canadian aviation licences to the federal Regional Aviation Medical Officer.

   Advice about the implementation of this new process was forwarded to the Motor Vehicle Division for possible similar application respecting drivers' licences.

Case History 7

Accidental. Boy was discovered wedged between the mattress and frame of his crib.

Recommendations:

1. Because public health nurses visit virtually all new parents in Calgary there should be an immediate review of their policy concerning crib safety. Instruction to parents about crib safety should be mandatory. A written check list should be employed and should include an examination of any crib in use.
2. The publication by Consumer and Corporate Affairs, Canada entitled "Is Your Child Safe?" makes no mention of the danger presented by mattress hooks becoming detached from the frame of the crib. This should be revised immediately and it should have wide circulation.
3. Communication must be effective. It is self-evident that children are left unattended in cribs for significant periods of time. The public interest is obvious and a comprehensive advertising campaign should be employed and when necessary, by use of all existing media, to alert parents of any dangers to their children. This should be a governmental responsibility and at public expense.
4. Effective communication should be made to health units, maternity wards, doctors, etc. by a specific agency of the Department of Consumer and Corporate Affairs. An agency should be created that is identifiable and answerable for any failure to alert the public in the manner described about hazardous products.
5. Legislation should be considered that is similar in other countries that would provide for stringent requirements on manufacturers to notify government immediately about any potential danger in the use of one of their products and should be required to employ extensive advertising under the direction of the Department of Consumer and Corporate Affairs.

6. A registration system should be employed to record the name and address of each purchaser of a child's crib so that timely warnings may be made when defects are discovered. It would be most desirable that registration be made by the retailer at the time of the purchase.
7. The Department of Consumer and Corporate Affairs should have the power to force a recall of manufacturers if it were deemed necessary.
8. A more comprehensive survey should be employed for all children's accidents which would include a detailed and specific description of the nature of the accident and its cause so that effective steps may be taken in an expeditious manner to prevent any recurrence.
9. There should be a complete re-examination of the present method of the construction of cribs to modify the design with a goal to prevent the mattress board becoming detached from the frame of the crib. If safety devices must be employed to maintain the convenience of present models, such as the Stork Craft safety plugs, they should be designed in such a manner that the devices are permanently attached to the crib. At the very minimum a prominent warning plate should be attached to the appropriate area of the crib. Warnings about safety devices should occupy a highly visible place in instruction sheets that are provided with the cribs. These modifications should be contained in the regulations and enforced by legislature.

Replies:

ALBERTA CONSUMER AND CORPORATE AFFAIRS

Since the recommendations referring to Consumer and Corporate Affairs relate to the federal department and federal legislation, the Minister has directed Alberta Consumer and Corporate Affairs to continue to cooperate with the federal department in the dissemination of information province-wide and actively pursue consumer education in order to help people avoid further tragedies.

CONSUMER AND CORPORATE AFFAIRS, CANADA

1. Arrangements have recently been made for departmental information on product safety to be sent directly to provincial authorities for health and consumer affairs.
2. A booklet entitled "Is Your Child Safe?" is distributed widely and is amended as needed. Specific issues with individual products are dealt with through various warning bulletins, information bulletins or news releases.
3. Although the Department utilizes numerous means to communicate safety messages to the public, the desired level of effectiveness and efficiency will only be achieved when responsibility is assumed by all parties concerned including provincial authorities, medical institutions, industry and the media.
4. With respect to the cradles and cribs regulations, these have recently been revised with a view to making them more stringent, particularly in the area of mattress support mechanisms. Under the revised regulations, it is unlawful to sell, advertise or import into Canada cribs which do not meet the new regulations. Sanctions will continue to be provided under the Hazardous Products Act for any failure to comply with the new regulations. The new regulations also require that a warning concerning proper use be permanently affixed to each crib sold.
5. Although the Hazardous Products Act does not enable the department to order a recall or to require manufacturers to notify the government about any potential hazard in the use of a product, the Act does allow for the seizure of non-complying products.
6. Beginning in 1986, the surveys will include more information covering the circumstances leading to product-related accidents.
7. It was decided in consultation with industry representatives and other interested parties that registration would more appropriately be dealt with by the individual manufacturers.

CONSUMER AND CORPORATE AFFAIRS, CANADA, PRODUCT SAFETY BRANCH

1. Our plans include distributing our publication entitled "Is Your Child Safe?" to the provincial health units for use in their prenatal classes and postnatal visits. Copies will also be made available to Alberta hospitals.
2. It is my intention to speak to as many of the Public Health nurses in Southern Alberta as possible on the contents of this pamphlet.

CALGARY LOCAL BOARD OF HEALTH

1. It is not, in our respectful submission, reasonable or practical to expect a nurse to carry out a home inspection of all the factors in an infant's environment which might pose a hidden threat to its well-being. This is particularly so in respect to matters in which a nurse is not trained to evaluate, which would include the assembly of furnishings.
2. We will continue to endeavour to alert parents to specific and hidden dangers which may affect their children. We will ask our Community Health Nurses to continue to watch for obvious hazards and when they observe them to alert parents.

CALGARY HEALTH SERVICES

1. No prior information that this product was a hazard.
2. The responsibility for guaranteeing that all unsafe products should form a mandatory discussion point in each of our postnatal visits does not formally exist.

3. We visit over 11,000 newborns annually and the expectation of an individual 'safety review' of all potentially hazardous items by our nurses on this initial visit is to a great extent unrealistic.
4. Our attention to safety is sincerely practised but there are many competing concerns which could well preclude a tour of the home verifying all conceivable established and non-established hazards.
5. In the case of cribs, a large number of mothers have not even yet acquired a crib for their new infant by the time of the home visit. I will advise you of the outcome of our board meeting. The report will be seriously reviewed.

ALBERTA SOCIAL SERVICES

The Federal Cribs and Cradle Regulation was amended to ensure that all cribs sold after that date meet rigorous safety and durability standards. Alberta's Day Care Regulation has been amended to require that all cribs used in day care centres meet the new federal standards.

STORK CRAFT

Acknowledged receipt of the recommendations.

Case History 8

Homicide. During a robbery, the deceased refused to surrender and threatened a police officer who shot him.

Recommendations:

There should be a complete and comprehensive review of the policies and procedures followed by the City of Edmonton Police. This should be conducted by a group or committee which has on it as members, in addition to the City Police members, one or two knowledgeable members of the public, and one or two senior members of one or more other police forces of equal or greater size.

Replies:

CHIEF OF POLICE, CITY OF EDMONTON

The Solicitor General has referred the findings and recommendations of the Fatality Inquiry for the attention of the Edmonton Police Commission, with a request that the Committee conduct a review consistent with Section 25 of the Police Act.

ALBERTA SOLICITOR GENERAL

A committee was established by the Edmonton Police Commission and it unanimously approved of the policies and procedures followed by the City of Edmonton Police Department in connection with this case.

Additionally, the Alberta Solicitor General met with all other Alberta police forces and reviewed their policies and procedures respecting similar police functions. The police commissions were advised of the Minister's support for the policies and procedures practised by their respective services.

Case History 9

Natural. Decedent's wife, attempting to summon Morinville Ambulance Service, neglected to dial long distance prefix 1. A neighbour telephoned 911 for emergency assistance, however, the area does not receive this service. An ambulance was dispatched from Glenevis, 40 kilometres away, as the Morinville service could not be reached.

Recommendations:

1. Something should be done to disabuse rural residents of their impression that the 911 Emergency Service applies to their localities. Television and other media should make it clear in advertising that the 911 system does not apply to rural areas. In addition, rural telephone books should contain a prominent notice on the emergency page that the 911 service does not apply.
2. Rural ambulances especially should be equipped with radio telephones sufficient not only to reach their dispatcher but also to reach an intended destination so as to get better directions.
3. Such ambulances should be supplied with detailed maps of the areas they are expected to service.

Replies:

ALBERTA GOVERNMENT TELEPHONES

AGT will arrange to provide additional reference on the inside cover of the telephone directories under AGT's control to indicate that 911 service does not apply in rural communities. Reference that 911 service is not available in the rural communities will also be made at the front of each community's listings in their respective telephone directories.

Prior to each directory canvass, an "emergency listings" letter is sent to the respective town or county administrator. The responsibility is the administrator's to determine the ambulance service that can best service the needs of the community and advise the directory department of all changes, additions or deletions.

MORINVILLE EMERGENCY AMBULANCE SERVICE

1. We are equipped with a communication system that reaches far beyond our response area.

2. Both vehicles are equipped with maps, and we never send drivers out to areas they are not totally familiar with.
3. We never take calls that are closer to another service.
4. Our telephone is manned 24 hours and we have never before heard of anyone that did not get an answer.

ALBERTA AMBULANCE OPERATORS' ASSOCIATION

The information will be circulated to the Alberta Ambulance Operators' Association. As well, the Executive will be pursuing with AGT the development of an identification system to assist emergency operators as well as citizens in rural areas in accessing appropriate ambulance services.

LIFE STAR AMBULANCE SERVICES

1. Felt that the AGT Directory should also be required to list under the emergency listings at the front of each area listing the numbers of all ambulance services within that particular area, not just the one service which is contracted to a particular community which happens to be the centre of a particular phone exchange, leaving other communities with that exchange without proper representation for their communities.
2. Our vehicles were equipped with mobile phones after this occurrence, once we obtained Federal Department of Communications approval of our licence request.
3. All required maps are in place in both our units and our dispatch centre.
4. We have established a policy which requires all staff to be assigned to members familiar with the operating areas for a training period of not less than 30 days, thus assisting to eliminate the problem of being unfamiliar with the operating area.

Case History 10

Accidental. The deceased was taken into custody by police and placed in a drunk tank. His belt was removed and it is considered likely that his trousers fell causing him to lose his balance and strike the back of his head on the concrete floor. He subsequently died in the hospital in Edmonton.

Recommendations:

That investigation be undertaken by the appropriate agency in an effort to discover a wall and floor cushioning material suited for use in police drunk tanks, non-porous, easily cleaned and not susceptible to damage by intoxicated prisoners.

Replies:

ALBERTA SOLICITOR GENERAL

The Department of Public Works has been advised of the recommendation in this case and in any future modification to existing facilities or the construction of new facilities that provide accommodation for public inebriates will take into account the need for proper materials to be applied to walls and floors.

R.C.M.P. "K" DIVISION

The recommendation has been forwarded to our Property Management Branch in Ottawa. I have been informed that a committee has been selected to examine the force's holding cell facilities.

Case History 11

Suicide. Deceased was an inmate at the Drumheller Federal Penitentiary when he committed suicide.

Recommendations:

1. No method or equipment existed for recording if and when inspection rounds are made by Correctional Officers. These should be implemented for each unit.
2. Prisoner's cell was not entered as soon as safely possible. Require better instructions or a change in policy to deal with apparent suicide victims.

Replies:

DRUMHELLER INSTITUTION CORRECTIONAL SERVICE CANADA

1. A new procedure will necessitate the officer conducting the round to notify Main Control that they are commencing the round. Main Control Staff record the time the call was received. Upon completion of the round the officer shall notify Main Control.
2. Procedures for entering cells are outlined in the standing orders of all major institutions of this region.
3. To improve response time, the staff working from 2300 hours to 0700 hours are to be issued, and carry, a portable personal alarm.

Case History 12

Suicide. A terminally ill patient at Three Hills Health Care Centre revealed that he had taken a drug overdose and refused treatment.

Recommendations:

1. For these types of patients who are ill to that extent and taking drugs, controlled drugs, a better check of personal items when being admitted to ascertain the

existence and quantity of drugs being brought in by the patient.

2. A closer and more certain watch of these patients when being supplied drugs by the hospital staff to make certain that they are, in fact, being consumed rather than simply being hoarded.
3. For these types of patients, a more thorough search of the patient's room if there is good reason to believe drugs are being kept in large quantities. I think especially if something was observed or if there was some evidence of the patient talking about suicide or death.
4. If we want to prevent suicides in the hospital, then there has to be some direction either from the Medical Association or some other body that would determine what attitudes the doctors and nursing staff should have with respect to this issue.

Replies:

ALBERTA HOSPITALS AND MEDICAL CARE

1. It is normal practice at Three Hills Health Care Centre that on admission, personal belongings are inspected and patients are requested to declare all medications that they are bringing into the hospital. Any medications that are declared or uncovered as a result of the inspection are removed and sent home with either relatives or friends.
2. Current nursing practice and procedures at the hospital direct that nurses administer medications to patients. This includes offering the patient liquids after the oral medications have been placed in the patient's mouth.
3. An initial routine room search was conducted by the nursing staff in response to the patient's expression of suicidal thoughts.

   It should be recognized that with an ambulatory patient, a thorough search of the patient's room is not exhaustive in the search for drugs. I suggest that it would not be reasonable to expect nursing personnel to undertake a facility-wide search, particularly when room searches did not produce indications of a drug hoard.
4. Although the Department cannot ensure appropriate attitudinal responses on the part of the staff working in a hospital environment, normal policies and practices would appear to have been adequate for the control of restricted drugs.

THREE HILLS HEALTH CARE CENTRE

1. Recommendations #1, #2, and #3 were being carried out prior to the incident and are continuing to be carried out at present.
2. Regarding the final recommendation, we have spoken with our Medical Staff and they will be taking up this question with their people.

Case History 13

Suicide. Deceased was in a cell in the assessment treatment unit of the Fort Saskatchewan Correctional Centre when he committed suicide.

Recommendations:

1. That the recommendations of the Board be carried out without retrenching.
2. If an ambulance is not made available to the institution, then the policy must be instituted that an ambulance be called at all times of medical emergency.

Replies:

ALBERTA SOLICITOR GENERAL

1. Staffing on the midnight shift has been increased for the Mental Health Unit.
2. The Department has undertaken a new class of Correctional Workers who are trained to a greater extent in inmate counselling and care.
3. The Centre has reinforced its directives with the general staff and has changed its operating procedures to ensure that an ambulance is called at all times of medical emergency.

ALBERTA AMBULANCE OPERATORS' ASSOCIATION

A copy of the findings has been forwarded to the Ambulance Services in the immediate responding vicinity to the Fort Saskatchewan Correctional Institute.

Case History 14

Accidental. Deceased was the driver of a car involved in a single vehicle accident. She suffered an epileptic seizure immediately before the accident.

Recommendations:

1. The Motor Vehicle Branch should review its procedures with regard to the issuing of an operator's licence.
2. That every applicant complete an affidavit of medical problems, if any, that have a bearing on driving ability. When any problems are disclosed then a medical examination could follow.
3. That all applicants for operator's (driver's) licences be required to formally make a medical statement that could affect their driving ability.
4. Applications by mail for operator's licences should be discontinued.

Replies:

ALBERTA SOLICITOR GENERAL, MOTOR VEHICLE DIVISION

1. As of September 1984, the application for an operator's licence was amended to encompass a declaration relating to health factors, for two major reasons. One was to ensure that clients were not merely asked whether or not they had a medical problem that could affect their ability to operate a motor vehicle, but more importantly, to have them declare this in writing.
2. Where a medical condition is noted, a medical report is requested to ensure that the client meets medical standards before an operator's licence is granted.
3. Since 1978 there has been a two-part photo identification licence. Therefore, the mail-in program was discontinued at that time.

Case History 15

Accidental. Deceased was in a work shop when a grinding disc exploded. A piece of the disc pierced his heart.

Recommendations:

1. Sanders and grinders should contain warnings (concerning their speed and their safe uses) when they are sold.
2. Drills and sanders should have an indication of the speed they run at.

Replies:

ALBERTA COMMUNITY AND OCCUPATIONAL HEALTH

The recommendations are already standard practice for most manufacturers. Further, the General Safety Regulation (AR 448/83) requires that:

"44(1) An employer shall ensure that

(a) the maximum number of revolutions per minute of an abrasive wheel or disc, as recommended for safe use in the manufacturers' specifications, is identified on the wheel or disc, and

(b) the maximum revolutions per minute of a grinder output shaft is identified on the grinder."

ASTRO PNEUMATIC TOOL COMPANY

No reply to date.

WHITEHORSE CONSTRUCTION

No reply to date.

Case History 16

Accidental. Deceased was on his first shift of employment with a drilling rig company when a pipe broke free and struck him on the head. He subsequently developed a cerebral blood clot and, despite surgery, died.

Recommendations:

1. A specific training course with certificate for all types of oil rig workers.
2. All those in charge of hiring for each employer sit down with a potential employee and review his credentials as well as explain to him the type of rig being used by the particular employer. Have the employee explain in his words with a diagram his understanding of the workings of the rig.
3. Install guard rails on all catwalks.
4. Requirement that all drilling rig operations involve a minimum number of employees for each stage of operation, i.e. in this particular operation, a fifth man.
5. Manufacturer's regulations to provide that elevators be either:
   A. double latch lock system or
   B. single latch with a bolt lock system. Regulation should prohibit the use of any equipment that does not meet these specifications.
6. Any equipment that breaks or is damaged must be repaired immediately with no improvisations or temporary repairs permitted.
7. Drilling regulations be drafted by government and a number of experienced employers in the industry to reflect specific safety components and safety methods rather than speak in generalities.

Replies:

ALBERTA COMMUNITY AND OCCUPATIONAL HEALTH

1. Training courses applicable to all levels of oil rig workers are available.
2. The industry has developed orientation programs for new staff which are similar to the suggested program.
3. The recommendation for provision of guardrails on all catwalks is not considered to be practical as it could in itself create a hazard.
4. Regulations speak to the requirements of direction and instruction of workers and also address the matter of communications.
5. Regulations meet the intent of the recommendation. The October issue of the *Occupational Health and Safety Journal* provided publicity to the matter of drilling elevators.

6. Regulations speak to this recommendation.
7. Industry took an active role in the development of the general safety regulation. The majority of provisions are performance-based and describe the safety objectives to be met.

HEMSING DRILLING

1. The Canadian Association of Oil Drilling Contractors (C.A.O.D.C.) is looking at the need for designing further training for rig workers.
2. We encourage our employees to view orientation films at our Brooks Office. We are producing employee handbooks to be read and signed by all employees prior to commencement.
3. We feel it would be impossible to install handrails on any catwalks, but the request will be presented to the Canadian Association of Oil Drilling Contractors Safety Committee Meeting.
4. We feel that a supervisor at the pipe tub could not have prevented the accident.
5. The elevators were double latched and proven to be in good order.
6. Recommended that all rope be removed from such equipment.
7. Our Safety Officer has agreed to discuss this matter with the Canadian Association of Drilling Contractors Safety Committee.

CANADIAN ASSOCIATION OF OILWELL DRILLING CONTRACTORS

1. Because there are several different types of drilling rigs, the only sound training is "on the job training".
2. Orientation of all new employees is presently a requirement of all drilling contractors.
3. The recommendation to install guard rails on all catwalks is not practical.
4. The installation of a shut-off button is not practical and has the potential of being even a greater hazard.
5. The Safety Committee agrees with this recommendation.
6. Again, the Safety Committee agrees.
7. The regulations, as they exist, reflect all that is necessary and only require correct interpretations.

Case History 17

Accidental. After spending an evening drinking, the deceased drove away from Lancaster Park CFB Edmonton. He was allowed to pass through a spot check by military police at the main gate. Soon after, the car which he was driving collided head-on with another vehicle.

Recommendation:

More care should be exercised by persons operating the main gate and any other gates that motor vehicles must pass through in leaving Lancaster Park.

Reply:

NATIONAL DEFENCE

Canadian Forces authorities have been and will continue to increase efforts, in every reasonable way, to guard against the dangers presented by intoxicated drivers.

Case History 18

Accidental. The decedent suffered an epileptic seizure while bathing and drowned.

Recommendation:

If there is a news bulletin issued by the Alberta College of Physicians and Surgeons, it is suggested that it contain the advice that physicians who have epileptic patients advise those patients to avoid taking baths and instead take showers.

Reply:

COLLEGE OF PHYSICIANS AND SURGEONS OF ALBERTA

This recommendation appeared in the July 1985 issue of the Alberta Medical Association *Newsletter*. The recommendation was also passed along to the Profession within the Winter 1986 *Report from Council*.

Case History 19

Suicide. Deceased was receiving psychiatric care. She was placed in care of foster parents with whom she wished to reside. Deceased ingested all medication available to her.

Recommendations:

1. Where the Department of Social Services has consulted with a psychiatrist and that consultation involves medication or decisions of placement, the placement or recommended placement at the time of the consultation should not be changed without additional consultation with the psychiatrist.
2. Where placement of any child under psychiatric care or taking prescription medication is changed, the person responsible for the new placement should be given a statement setting out:
   (a) nature of psychiatric care
   (b) full description of medication being given
   (c) restrictions which might be attached to use of medication.

Reply:

ALBERTA SOCIAL SERVICES

Procedures governing transfer of child welfare files, procedure for dealing with children at risk of suicide, responsibility for relationship with community resources, and characteristics of children at risk of suicide have been incorporated into the Child Welfare Program Manual. Standards and guidelines concerning medications prescribed for children in foster homes were distributed to Child Welfare.

Case History 20

Accidental. Child choked on a wiener while eating lunch at a day care centre.

Recommendations:

1. Parents be made aware of the need to instill in children proper eating habits.
2. Parents who are aware that their child is a "stuffer" rather than a "chewer" alert anyone who has care of the child of this propensity.
3. Parents and those who have children in their care should be alerted to the danger caused by cylindrical foods.
4. Consideration be given to the creation in Sherwood Park of an emergency treatment centre where doctors skilled in the use of a laryngoscope will be on duty 24 hours a day.

Replies:

A & D DAY CARE LTD.

No reply to date.

ALBERTA HOSPITALS & MEDICAL CARE

The establishment of an emergency treatment centre is not being considered at this time.

ALBERTA SOCIAL SERVICES

1. Licensing staff advised operators of day care centres and family day homes to immediately review emergency procedures, eating practices and first aid treatment. They were requested to ensure that children were properly supervised and seated while eating all meals and snacks and were cautioned that certain foods – nuts, seeds, fudge – should not be given to children under three years. It was also impressed upon operators that extra care should be taken with foods such as wieners, sausages and peanut butter.
2. Effective December 1, 1985 only a valid certificate in first aid and child care is accepted as satisfying the requirement under the Day Care Regulation: currently St. John Ambulance and the Canadian Red Cross offer courses leading to this certification.
3. Day care centres are required to have at least one person with a valid certificate on the premises at all times.
4. All family day home providers within satellite agencies are also required to hold a valid certificate.
5. Amendments are being drafted to the Day Care Regulation to include the new first aid requirements. A licensing manual and educational materials which make specific reference to choking prevention, food preparation and food services are being prepared.

Case History 21

Accidental. A large cement sewer pipe slipped off a truck and struck an oncoming van, killing the occupant.

Recommendation:

Because these trucks must manoeuvre curves and because the load is bound to shift, each pipe should be secured by a separate chain when being carried on a flat deck in a cross-width position.

Reply:

ALBERTA TRANSPORTATION

Requirements for proper loading of commercial vehicles are handled by the Motor Transport Branch. Section 3.34 of the Public Service Vehicles Regulations sets out safe loading practices for trucks.

Case History 22

Suicide. A patient at Alberta Hospital, Ponoka committed suicide off the grounds.

Recommendation:

That patients with suicidal tendencies at least sign out of the hospital before leaving the grounds.

Replies:

ALBERTA HOSPITALS AND MEDICAL CARE

This case has been addressed by the hospital and we agree that the revised policy is appropriate.

ALBERTA HOSPITAL, PONOKA

1. The Hospital Policies and Procedures on the patient observation level and privileges were reviewed and revised.
2. Specifically for patients under limited town privileges, the assigned nurse shall remind the individual patient to report back to the ward at the scheduled medication time.

Case History 23

Accidental. A swimmer died as a result of injuries sustained when struck by a motor boat while swimming.

Recommendations:

1. Boaters should be made aware of the danger of piloting and navigation of motor boats in *any* area customarily used for recreational swimming, and should be encouraged to minimize passage through such areas.
2. Boaters should be educated that while towing a water skier, the operator of the motor boat should not look at the water skier, instead devote his total concentration on the course of travel of the motor boat.
3. Consideration should be given to defining the term "responsible person" in connection with the lookout utilized while towing operations are in progress, by reference to chronological age or some level of maturity – whether this be done by legislation or by a public safety education program.

Replies:

SUMMER VILLAGE OF MEWATHA BEACH

We concur with the recommendations, however we have no responsibilities to the lake as it is outside of our boundaries. We are willing to educate our residents to become more aware of boating safety, through our recreation program.

ALBERTA FORESTRY, LANDS AND WILDLIFE

The Provincial Boating Restriction Review Committee will ensure that the municipalities associated with Skeleton Lake are contacted and made aware of the regulatory options available through the Boating Restriction Regulations (Canada Shipping Act) for protection of swimming areas.

BOAT SAFETY CHECK

During the past several years an average of 12 patrols were conducted annually by Boat Safety Check Organization members of Skeleton Lake checking an average of 200 boats annually. These patrols will continue to enforce the Criminal Code and Small Vessel Regulation Section pertaining to boating safety. The contents of the recommendations are continually drawn to the attention of boat operators wherever there is a perceived concern with safety.

JUSTICE CANADA

Although the imposition of penalties and civil liability should provide sufficient incentive to the pleasure craft operator to educate himself and take proper care in the operation of a motor boat, other remedies are available under the appropriate regulations.

CANADIAN COAST GUARD

No reply to date.

TRANSPORT CANADA

No reply to date.

For more information or additional copies of this report, contact:

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